Patient Information Form

Today's Date_____

Patient Name: First_____ MI____ Last_____ Nickname_____

Address: Street_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Mobile_____

E-mail address_____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number_____ Date of Birth_____

Drivers License #_____ State_____

Patient Employed By_____ Occupation_____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified?_____

Relationship to Patient_____ Home Phone_____ Mobile Phone_____

Is the patient a Minor? ☐ Yes ☐ No Full-time Student ☐ Yes ☐ No Name of School_____

Name of Responsible Party: First_____ Last_____

Date of Birth_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Mobile_____

Employer *(if different from above)*_____ Occupation_____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

Dental Benefit Plan Information

Primary Dental Plan Name_____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured_____ Date of Birth_____ ID Number_____

Policy Number_____ Patient Relationship to Insured_____

Secondary Dental Plan Name_____ Phone_____

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)*_____

☐ Advertisement_____ ☐ Local Dental Society_____

☐ Our Web site ☐ Other_____

Confidential Health History Form

Today's Date_____

Patient Name: First_____ MI____ Last_____ Date of Birth_____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No **Is your general health good?**
   If NO, explain_____
2. Yes / No **Has there been a change in your health within the last year?**
   If YES, explain_____
3. Yes / No **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain_____
4. Yes / No **Are you being treated by a physician now?**
   If YES, explain_____

   Date of last medical exam?_____ **Reason for exam**_____
5. Yes / No **Have you had problems with prior dental treatment?**
   If YES, explain_____

   Date of last dental exam_____ **Name of last treating dentist**_____
6. Yes / No **Are you in pain now?**
   If YES, explain_____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others_____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Corlico - Steroids				

Please list all medications you are currently taking_____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?**_____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain_____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why_____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when_____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature_____ Date_____

Physician's Name_____ Phone Number_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Dental Health History Form

Today's Date_____

Patient Name: First_____ MI____ Last_____ Nickname_____

What are your goals in coming to our practice today?_____

What is important to you in a dentist or dental practice?_____

What has been your experience with the dentist in the past?_____

Date of last radiographs (x-rays) and exam_____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)*_____

Former Dentist_____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

If you left your previous dentist, what are the reasons?_____

Have you had problems with prior dental treatment?_____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe_____

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If yes, why?_____

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why?_____

Would you like to discuss this concern with the doctor to learn about your relaxation options?_____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

☐ Jaw joint pain
☐ Clenching or grinding of teeth
☐ Discolored teeth
☐ Crowding/Crooked teeth
☐ Missing teeth
☐ Spaces in between teeth
☐ Loose tooth/teeth
☐ Tooth shape or size
☐ Unhappy with appearance of teeth
☐ Overbite
☐ Underbite
☐ Uncomfortable bite
☐ Old fillings *(gold or silver)*
☐ Old crowns
☐ Speech problems
☐ Too much gum tissue when I smile
☐ Tooth sensitivity to hot/cold or anything else
☐ Food gets caught in between teeth
If yes, where?_____
☐ Difficulty chewing
If yes, where?_____
☐ Bad breath
☐ Other_____

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when?_____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No

If yes, when?_____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method?_____

Are you interested in learning more about the following? *(check all that apply)*

☐ Teeth Whitening
☐ Orthodontic treatment
☐ Veneers
☐ Tooth-colored fillings
☐ Dental implants
☐ How to prevent periodontal disease
☐ At-home oral hygiene care
☐ Periodontal treatment during pregnancy
☐ Oral hygiene care for infants and toddlers

Financial Policy & Scheduling Policy

Patient Responsibilities: We are dedicated to providing our patients with the best possible care and helping our patients achieve optimum oral health. Toward these goals we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment for dental care is due at the time of service, unless other arrangements have been made. All financial arrangements will be discussed and a financial agreement will be completed in advance of performing any treatment with our practice. We accept cash, check, debit cards and all major credit cards.

Dental Insurance Plans: Your dental insurance benefits and payments are based on the terms of the contract negotiated between you or your employer and your dental insurance company. We are happy to help our patients with their dental benefits, allowing you to understand and maximize your coverage. As a service to you, we will file your insurance claim if you assign the benefits to Dr. Turk, agreeing to have your insurance company pay our office directly. If your insurance company does not pay our practice for services within a reasonable period, you are ultimately responsible for payment of treatment. We are required to collect your patient's portion (deductible, co-pay, or any other amount not covered by your dental plan in full at the time of service). If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

Scheduling of Appointments: We reserve the doctor and hygienist's time on our schedule for each patient procedure and are diligent about being on time. Thus, when a patient fails or cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require a 24-hour notice to reschedule an appointment. With less than a 24-hour notice of cancellation or failure to make a scheduled appointment, a fee of $95 will be charged to your account.

Authorizations:
I have read the above and agree to the financial and scheduling terms. _____ (*initial*)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to Dr. Turk. _____ *(initial)*

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice. _____ (*initial*)

I hereby acknowledge that a copy of this practice's Dental Material Fact Sheet has been made available to me. I have been given the opportunity to ask questions I may have regarding this Fact Sheet. _____ (*initial*)

Signature _____ Date _____
(Authorization must be signed by the patient or by the parent or legal guardian for a minor or when the patient is physically or mentally incompetent.)

Consent for Treatment: I understand that the information I have given today is correct to the best of my knowledge. I will notify Dr. Turk if I ever have any changes in my health or if my medications change. I authorize Dr. Turk to take radiographs and or any other diagnostic aids deemed appropriate in order to make a proper diagnosis. I hereby authorize Dr. Turk and his dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

Signature _____ Date _____
(Authorization must be signed by the patient or by the parent or legal guardian for a minor or when the patient is physically or mentally incompetent.)